Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN5684AGC	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MMK RESIDENTIAL CARE LLC	**711 WEST GOLDEN VALLEY ROAD RENO, NV 89506**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an initial State Licensure survey conducted at your facility on 7/28/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is requesting licensure for six Residential Facility for Group beds for elderly or disabled persons, Category II residents. The census at the time of the survey was zero. One sample resident file was reviewed and three employee files were reviewed. Regulatory deficiencies were found at the time of the initial survey were corrected. No further action is necessary. Please retain a copy of this report for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE